

IDAHO STATE BOARD OF SOCIAL WORK EXAMINERS
Bureau of Occupational Licenses
1109 Main St., Suite 220
Boise, ID 83702
swo@ibol.state.id.us

CLINICAL PRACTICE EXEMPTION - EMPLOYER SUPERVISION REPORT

Rule 201.04 – A social worker licensed in Idaho at the masters level prior to August 5, 2002 engaged in clinical social work and employed directly by a physician, psychologist or other social worker, or by a public or private agency, institution, hospital, nursing home, rehabilitation center, or any similar facility may meet the supervised experience requirement for clinical licensure upon submission of documentation prior to July 1, 2005 showing a minimum of one hundred (100) face-to-face hours of employer provided supervision. No more than seventy-five (75) hours of supervision may be provided by a licensed counselor, marriage and family therapist, or psychiatric nurse and no less than twenty-five (25) hours of supervision may be provided by a licensed clinical social worker, psychologist, or an individual licensed to practice medicine and surgery who practices in the area of psychiatry. A licensed social worker who meets the requirements of section 201 may continue to practice clinical social work until July 1, 2005. An individual practicing under this exemption must still pass the clinical examination as set forth in rule 350 prior to clinical licensure.

PLEASE USE A SEPARATE FORM FOR EACH SUPERVISOR

1. **Full Name** (Mr., Mrs., or Ms.) _____
2. **Mailing address** _____
Street/PO Box City State Zip
3. **Business address** _____
Street/PO Box City State Zip
4. **Date of Birth** ____/____/____ **Social Security No.** ____/____/____ **License #** _____
mm dd yyyy

Applicant Signature

State of _____, County of _____, ss.
Subscribed and sworn before me this _____ day of _____, 20 _____.

(seal)

Notary Public official signature
my commission expires _____

THE FOLLOWING MUST BE COMPLETED BY THE EMPLOYER/SUPERVISOR

1. Dates of supervised practice - From: ____/____/____ To: ____/____/____
mm dd yyyy mm dd yyyy
2. Total supervised practice hours: _____ Total face-to-face supervised hours _____

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(continued)

3. Evaluation of your supervisee, including clinical skills and knowledge and his/her application of knowledge and skills in clinical work. (Please use additional pages as needed)

4. Briefly describe the setting in which the candidates clinical work was performed.

5. Do you have any reservations regarding the candidate's ability to perform as a clinical social worker?
[] Yes [] No If yes, please explain. (Please use additional pages as needed)

Supervisor Name: _____

Degree & Discipline: _____

License # (include State(s) of licensure) _____

AFFIDAVIT

I hereby certify that the responses provided above are true and accurate to the best of my knowledge and belief.

Employer/Supervisor Signature

State of _____, County of _____, ss.

Subscribed and sworn before me this _____ day of _____, 20 _____.

(seal)

Notary Public official signature
my commission expires _____

To the Supervisor: Upon your completion of this report, please place in an envelope, seal, and return it to:

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